THE CLINIQUE.

A MONTHLY ABSTRACT OF THE CLINICS AND OF THE PROCEEDINGS OF THE CLINICAL SOCIETY OF THE HAHNEMANN HOSPITAL OF CHICAGO, ETC., ETC.

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THE CLINIQUE.

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Original Lectures.

GYNECOLOGICAL ELECTRO-THERAPEUTICS.

A CLINICAL LECTURE BY E. STILLMAN BAILEY, M. D., PROFESSOR OF THE MEDICAL DISEASES OF WOMEN, DELIVERED IN THE HAHNEMANN HOSPITAL, CHICAGO, DECEMBER 13, 1889.

The first patient that comes before you to-day is one that was treated here in the early spring, and her history I think you will find an interesting one. In my didactic course I have had many occasions to refer to electricity as a therapeutic agent of great value in the treatment of the diseases of women, and in my clinic I hope to illustrate all that I have claimed or advised. It would be quite impossible for me to enter deeply into this branch of gynecological treatment without revealing my enthusiasm for and confidence in this wonderful, though still mysterious agent. I do not wish to claim too much for it, nor am I unmindful that there is scattered over the world an army of ambitious, zealous, scientific workers, who are daily adding to our knowledge. What is now known of electro-therapeutics has been discovered within the last twenty years, and it may be truthfully said within the last eight or ten years. Many reasons might be pointed out why this therapeutic agent did not advance faster, or why it was not better re-

ceived at the hands of the practitioners. It might be an interesting discussion, but our time is too limited. It is sufficient to say that it now holds, by right of conquest, a prominent place in gynecology, and demands a respectful hearing. It stands to modern therapy in about the same position as an electric light does to the tallow candle. "The light of other days" has been almost forgotten, the modern methods seem to be better, and yet the way seems but just opening.

It was my good fortune to be a student of Dr. Georges Apostoli, at his clinic in Paris two years ago, and in this my first report of work in this line, I feel as though I were omitting very much that should be said in praise of the system he so thoroughly teaches. As a man, as a practitioner and as a teacher, he certainly commands my greatest admiration. His enthusiasm is contagious, and his extensive observation and patient industry constant sources of wonder.

As one of the methods of treatment that is offered to you for application, so far as relates to the diseases of women, I beg of you to at least give the same a share of study when at your chosen work.

ENDOMETRITIS, TREATED WITH GALVANISM—CURE—*Case No. 20,370.*—Mrs. C., (admitted as out-clinic patient, April 5, 1889), aged 26 years. She has had no children, but has had two miscarriages. The last one was in May, 1888. She has been ill for eleven months. She complains of a constant uterine hæmorrhage, accompanied with ovarian tenderness, a bloated abdomen and a condition of the bowels of alternating diarrhœa and constipation. *Nitric acid, 3x*, was prescribed, and a local treatment of *hydrastis canadensis* and a cotton tampon was applied.

April 12. The pains are relieved. The hæmorrhage is the same.

April 19. The flowing is increased. Curetting the uterus was advised, but as the patient could not remain in the hospital for the after-treatment, it was declined.

April 26. The uterine discharge is still very offensive and very copious. The mental condition one of constant dread and apprehension. Used galvanism. The large

abdominal electrode attached to the positive pole; the intra-uterine, platinum-pointed electrode (Martin No. 3) to the negative, or in the technical use, in place of the curette, I employed as a treatment for the endometritis and its prominent symptom the constant flowing, chemical-galvano-caustic, intra-uterine, negative.

May 3. The patient reported that the hæmorrhage ceased the day after the treatment, and there has been no return during the week. For the anemic condition with its influence upon the digestive tract, prescribed *ferrum et strychniæ cit. 3*, a powder, two grains, every three hours.

May 10. Improving in every way. Complains of some headache.

Nov. 8. The patient returned for the first time since the above date. She reports that the hæmorrhage ceased with the one galvanic treatment on April 26, and has not returned. The menses have returned every three weeks, last four days, and are normal. For diarrhœa with the characteristic, great prostration immediately following liquid stool, with much mucus and no tenesmus. *Aloe. 3.*

Dec. 6. Reports no lasting improvement. *Aloe. 30.*

Dec. 13. Complains of cutting, clutching pain about the umbilicus, colic attending the diarrhœa. *Colocynth, 30.*

Dec. 20. Improved in every way. Menses returned during the past week; normal except the interval was only three weeks.

I am pleased to have this patient before you, that you may hear her repeat that portion of her clinical history which concerns us most, that the persistent flow of eleven months, the sequalæ of an abortion at the fifth month, has been cured, or it seems warranted to call it cured after seven or eight months have elapsed without any return. This certainly is not rushing into print before the patient has been granted a chance to get well.

The case is certainly a unique one for clinical illustration. Not all cases would thus respond to a single application, nor would the poles be so placed every time. I can only offer it as one of the expedients which, in your hands, may be measured by success under like conditions. I cannot refrain from referring to some very recent literature on the subject of "raclage" or curetting, by Dr. Georges

Apostoli; and I know that you will be interested in hearing what he has written. Under a very recent date he says: *

"To-day much honor is being given to "raclage," which, born in France, has been dormant for many years. Without wishing to reflect upon a surgical procedure of great merit in certain cases, I wish to draw attention to the superior and similar advantages of the raclage by galvano-caustic intra-uterine.

(*a.*) It is a method so simple of application that any physician, no matter how little skill he may have as a gynecologist, can employ it with success; it requires no assistant. (*b.*) In general it is so bearable that chloroform will not be called for, which, indeed, is only needed in certain cases of punctures. (*c.*) Only a few hours of repose after the operation are needed, and it does not demand, as does curetting, that the patient go to bed; working women can continue their daily avocations without interruption. (*d.*) It is a less brutal operation, since the doses are progressive, and increased only with the tolerance that is also progressive. It is not instantaneous. (*e.*) It is not contra-indicated in any acute inflammatory state, and only needs a more strict observance of detail to render it tolerable in different doses, according to the case, and according as well to the patient, for different doses at different periods may be demanded in the same person. (*f.*) It is an action which obeys, with precise and mathematical obedience, the hand controlling it. One can dose it and measure it exactly—the general intensity used, the density of the electrodes and the duration of the application—being the three factors concerned. (*g.*) It is an active force, producing an action as pronounced as one wishes, which can be localized at will, and which can be confined to a very limited portion of the uterine mucosa, if one wish. (*h.*) It is an absolutely harmless cauterization, if one make use of the antiseptic, or rather aseptic, precautions that I have indicated. (*i.*) According to the duration of the *séance*, and the intensity used, changes may be wrought at will, just as especial effects may also be engendered according to the pole made active. Remember that bases are negative and acids positive. (*j.*) But, apart from its action above cited, it has a much more profound trophic and vital action, which is felt along the whole interpolar tract of organic tissue. It thus has an action of

* Introduction. Gynecological Electro-Therapeutics. Bigelow, June, 1889.

much wider extent than surgical raclage, since the whole uterine parenchyma and the adnexæ are affected. (*k.*) If surgical raclage is often followed by a return of the disease, and by bad functional results which it was destined to eradicate, I can affirm that such things are much less frequent after this galvanic treatment, which usually requires several *séances* to bring about the desired results, but which results are usually permanent, as I have observed at the clinlc in many women, in whom, after many years' cessation of treatment, there had been no return of the complaint. (*l.*) Finally, in addition to these advantages of intra-urine electro-therapy which justify its employment, it is the marvelous antiseptic and sterilizing power of the galvanic current which is destined to play the preponderating role in gynecology since the modern teachings of micro-biology give to pathogenic microbes a controlling power."

I am not willing to decry the surgical operation of curetting of the uterus when therapeutic measures have failed, but I would like you to remember that the action of the galvano-cautery goes further than the surgical. The inter-polar action, *i. e.*, the action upon the whole muscular fibers of the uterus and adnexæ, is a most powerful adjunct in the re-establishment of the physiological functions.

I may add for the information it contains, that I have had equally good results in private practice in cases when formerly I used the curette. The reason for employing the negative pole intra-uterine, a question that I know you are asking, was that I deemed it a much shorter cut to dissolve by negative cauterization the diseased mucosa and by producing an increase of the flow temporarily, aid the cleaning away of the debris of a placental attachment or a fungoid growth, the result of an excessive but perverted nutrition, and thus assist in the attempt to re-generate a healthy membrane, rather than by positive cauterization simply seal up the bleeding vessels to stop the flow. The positive pole is more apt to stop a hæmorrhage and quicker, and it also produces much less of congestion than the negative, and yet I have the same experience as many others, that the latter is a more powerful agent to provoke absorption.

In one of the cases in private practice that I may be pardoned for referring to by way of illustration, I had five months before beginning treatment attended the young woman in her first labor, the fœtus was dead and decomposed almost beyond recognition in a shapeless mass. It was at the sixth month. The placenta was easily removed and before leaving her, the womb was thoroughly washed out and antiseptics were freely used. For two weeks the lochia was simply stinking, though she escaped without absorption or any serious puerperal complications. In one month she was up and quite recovered, all except the flow, which did not entirely cease. Its odor was very unpleasant. Curetting and galvanism were recommended. The patient being a school-teacher could not submit to the loss of time from school. Galvanism was tried. The cervical canal was widely open, sufficiently so to take a small tampon of absorbent cotton wet with a disinfecting solution and applied by wrapping around the dressing forceps. This was easily passed into the uterus, and the cavity was thus thoroughly cleansed, then the intra-uterine negative cauterization was used, fifty milliamperes six minutes. At the next report one week after the patient declared herself entirely free from the flow for the last three days, for the first time in five months. At the second application the canal would not receive the electrode, and a smaller one was substituted. This patient is also cured. The prolapsus and the peri-uterine tenderness has been cured. Remedies for several months may have relieved her some, but it remained for galvanism to cause the resolution in this case.

SALPINGO-OVARITIS. RELIEF.—*Case.*—I refer to a case in private practice of salpingo-ovaritis which started as a case of endo-metritis following repeated intra-uterine treatments with iodine tincture and the applications to the cervix of lunar caustic. The patient had suffered in this way for years. After removing to this city she came under my care. She was suffering from a left lateral displacement of the uterus, which seemed anchored, either by ad-

hesions because of pelvic peritonitis, or from a shortening of the broad ligaments. For two years I followed up the case with local applications and remedies as seemed indicated by the symptoms. The result was to me not at all satisfactory, though I made my patient comfortable by the palliatives. She could neither walk nor ride, so continuously tender was the abdomen in its lowest segment. The electrical treatment was the beginning of better days for her. I gave in her case vaginal faradization, a very mild primary current interrupted, and continued in duration about fifteen minutes each sitting. The current of *tension* did, in this case, just what it may always be expected to accomplish—bring relief from pain. I am also convinced that somewhat of absorption of old adhesive bands, that formed the anchorage, has taken place. The position of the uterus, after three months of treatment, is nearly normal and the tenderness is very much lessened; there is enough of pain to constantly remind her of my caution against overwork, etc. She has recently walked a couple of miles, and says that she anticipates the bi-weekly treatments by wishing they were daily; the faradization rests her and frees her from pain.

In many of the common ills, that are transitory, such as the pains anticipating a menstrual period, or the backache that follows too much exercise preceding the menses or immediately following, or the irregular circulation caused by pelvic congestions, the electrical current is a most excellent form of treatment.

Fibroid Tumor of the Uterus Symptomatically Cured. —*Case.* Large, intramural, greatest projection backward, of thirteen years growth, very dense to the touch, cervix and body of the uterus lost in the mass, the cervical canal very tortuous, the os uteri displaced forward. The patient is thirty-eight years of age, married, no children, no miscarriage. She has suffered for years with the following kind of pains: In the right ovarian region a violent throbbing, a tender spine, a constant beating pain at the base of the brain; dysmenorrhœa, obliging her to pass the menstrual week in bed almost every month; the prolapsus uteri is very marked, the mechanical pressure of the growth caused frequent micturition day and night, obstinate constipation alternating with diarrhœa; the reflexes were marked, giving nausea, a harrassing cough, a violent form of head-

ache, and at times melancholia, almost despairing of ever being well again.

The pain in the growth at times is quite marked. Sometimes there is metrorrhagia, sometimes an acrid leucorrhœa; numbness of the legs from the knees down, also from the elbows to the finger tips; burning in the stomach, with distress after each meal; the temperature normal, pulse feeble and below normal most of the time; face pale, anæmia quite marked.

The patient came to me from a neighboring State for examination, diagnosis and prognosis, the question of abdominal hysterectomy having been mentioned to her by her physician as a possible operation for her relief, and so worn out had she become with this long standing and gradually increasing painful condition that she was ready for any reasonable procedure offering relief. She was very intelligent, and had become conversant with the nature of her trouble and the dangers of an operation, yet she did not hesitate. "Whatever you do," she said, "do not give me any more *ergot*. *I really believe that I have taken enough of this drug during the few years past to drown myself in."

Having advised the treatment by galvanism, the method of Apostoli, as I had been instructed by him to use it, I copy from my note book the entire record of this case, nor is it chosen for the reason of its favorable report, for others have done as well :

A few applications of the sound were necessary to open the tortuous cervical canal.

February 6th. Commenced galvanic treatment. Used Martin's abdominal electrode and a No. 3 (three millimeters) platinum-tipped sound in the uterus. Gave sixty milliamperes (McIntosh) for four minutes. Electro-negative pole in the uterus. Treatment aggravated all symptoms, but started a *profuse watery discharge*.

February 9th. Gave thirty milliampere five minutes; electro-negative pole in the uterus.

February 11th. Same treatment.

February 13th and 15th. Gave fifty milliampere three minutes; electro-negative pole in the uterus.

February 16th. Menses returned. The flow became established without her suspicion, without premonitory

*For an extensive report of fibroid tumors of the uterus (151 cases), treated with ergot, see Report of Ninth International Medical Congress, page 594, vol. II.

symptoms, and for the first time in many months she did not have to go to bed because of pain. During the period, she repeatedly walked out and did some visiting, what was to her a great encouragement.

February 22d. Resumed treatment by employing a current of seventy-six milliamperes six minutes; electro-negative pole in the uterus. This application caused much burning; "felt hot" in the uterus. The ovarian pain, left side, increased, pain lasting all night.

February 25. Forty milliamperes fifteen minutes; electro-negative pole in the uterus. Great freedom from pain and of the throbbing for two days past. "Improving in every way." "The absence of the throbbing at the base of the brain brings such a relief."

February 28. Sixty milliamperes ten minutes; electro-negative pole in the uterus. "A profuse watery flow, attended with great relief in the tension of the parts being noticed since the last treatment."

March 1. Same treatment repeated; watery discharge still profuse.

March 4. Eighty milliamperes for ten minutes; electro-negative pole in the uterus.

March 6. Forty-five milliamperes for fifteen minutes; electro-negative pole in the uterus. This milder form of cauterization seems to help her most, producing almost entire relief in all the organs of the body for several hours or even days. The most permanent relief for months.

March 8. Ninety milliamperes for fifteen minutes; electro-negative pole in the uterus.

March 11. One hundred and fifty milliamperes for two minutes; electro-negative pole in the uterus. This treatment was poorly sustained. Pain in the ovary very severe, and the whole spine very sore for two days following. Gave mild form of galvanism along the spine.

March 13. Ninety milliamperes for ten minutes; electro-negative pole in the uterus; watery discharge very free.

March 15. Menses returned; pain very slight; "would say they were about right."

March 22. One hundred and twenty-five milliamperes for three minutes.

March 23d. Sent for me. Complains of great pain in the ovary and had had a hæmorrhage; blood bright red, very copious. Ovarian tenderness; spine very sore. The hæmorrhage was not repeated; pains yielded promptly to Apis. Mel. 6x trit. Rest in bed one day only.

March 31st. Resumed electrical treatment. One hundred and twenty-five milliampères for ten minutes. Electro-negative pole in the uterus; no unpleasantness.

April 3d. The patient says that since the last treatment she has been feeling better in every way than for many months; same treatment repeated.

April 6th. She says that she is improving very rapidly, the watery flow is now very copious and "it is attended with such relief."

April 7th. The patient came to the city expecting to stay only a week, but has remained for two months. Her improved condition sufficiently warrants her in discontinuing treatment for a while, so she returns home to-day.

The local examination finds, after two months' treatment, the tumor to be much softer, the cervix and body of the uterus clearly distinct from the mass. The throbbing in the side, back and at the base of the brain, is very much better; for days at a time it is entirely gone.

July 9th. Patient returned to resume the electrical treatments. She says that her symptoms are all better than when she left here. One hundred milliampères, five minutes, electro-negative pole in the uterus; treatment well sustained.

July 11, 13, 15th. Same treatment as above.

July 16th. Sixty milliampères, for twelve minutes, electro-negative in the uterus.

July 17th. Menses returned; aside from pain in the left ovary she was remarkably well.

July 27th. Eighty milliampères, for ten minutes; the ovary, spine and stomach seem very sensitive to the electrical treatment, and for July 29th, Aug. 1st, and 3d, gave sixty milliampères for ten minutes.

August 5th. She had a very copious hæmorrhage, which lasted at intervals for five days. Though losing much blood her general health seemed excellent. She resumed electrical treatment again Aug. 9th. Twenty-eight milliampères, for five minutes, electro-negative pole in the uterus.

August 22, 24, 26th. Fifty milliampères for twelve minutes. Improvement in all her symptoms very marked.

August 28th. One hundred and twenty-five milliampères for ten minutes, electro-negative pole in the uterus.

August 31. One hundred and fifty-one milliampères for twelve minutes. The patient again discontinues treatment.

The following conditions are now noted: The tumor is very much softer, it is also much reduced in size, the patient thinks a half.

The throbbing sensations which were present all the time when she first came are nearly gone. When they return they are not as severe. "I have no hesitation in saying that I feel a decided improvement in every particular, but especially is it noticable in the pelvis and in the tumor."

Under cover of December 9th, in a letter written from her home, the patient instructs me to add to this report:

"I still have some of those very severe headaches, and some throbbing and some pain in the ovary (left), but am feeling fifty per cent, or even more, better than when I saw you last. *The greatest change is in the tumor and in the uterus. It is very much smaller and softer.* The prolapsus is very much less, and I am certain could I have remained for a longer treatment that I should be still better."

To keep from the expression of my opinion, which would be biased by the enthusiasm that comes from a successful solution of the difficult problem of her cure, I have given the patient's notes during the progress of the treatment. I am aware of the responsibility I assume, and also of the necessity of accuracy of statement when I say to you that I believe that this patient is symptomatically cured of her fibroid tumor.

Taking it for granted that as yet you are not familiar with the claims of this method of cure, as put forward by Apostoli, let me review this discussion and give a short analysis of this case, and see how very well his theory and these facts agree. In my case the patient was aware of a growth in the pelvis for thirteen years. Its probable cause was the wearing of a poorly adjusted and illfitting pessary, and working daily with a heavy, hard-running sewing machine. She was gradually getting worse from year to year, the fibroid kept increasing, the mechanical pressure was greater —interfering with walking. There was dysmenorrhœa and the whole train of nervous reflexes, etc. She was demanding a cure and what other treatment would have given it as this has?

In his most recent letter, reviewing his methods* of the treatment of uterine fibromas Apostoli says :

"For the hundredth time I will repeat that my treatment has nothing to do with the unvarying radical cure of fibromas: if such result is sometimes observed, it is the exception, and electro-therapy up to the present time has for its sole ambition *the symptomatic cure of the patients, and the parallel but limited retrogression of the fibromas.*"

Let us also see what this claim amounts to, as stated by the same author.**

"I affirm again, as I have already written, that the method properly used (as I have directed) has effected, ninety-five times out of one hundred, in uterine fibromas :

1st. An anatomical diminution which does not advance so far as the complete dispersal.

2d. The quick and lasting cessation of hemorrhage.

3d. The disappearance of all the symptoms of compression.

4th. The symptomatic restoration of the patient."

It would seem, therefore, in this case, which is but one of the ten cases of pelvic tumors that have fallen under my care during the year, that a cure has been effected, and that the patient is symptomatically a well woman; well in the sense of a removal of a cause. Two pertinent questions can be answered by the experience of operators in this specialty. Without complete anatomical dispersal why claim a symptomatic cure? Will not the fibroid tumor redevelop when the electrical treatment has ceased? To the former the reply is, when development or growth has once been arrested, the process afterward is one of absorption and dispersal, or simply atrophy without necrosis, rather than recovery of nutrition and reappearance of growth.

To the latter, the clinical experience is that they may remain stationary as to size, but do not again enlarge, but they may continue to diminish to complete dispersal. I know you are asking another question; and since the case

*Introduction. Gynecological Electro-Therapeutics, by Bigelow. June, 1889.

**Ibid. page 65.

that I have selected to report, as a typical one, did not have much to do with the factor of hemorrhage, you are wondering what the effect of the electro-negative pole, galvanic current, had to do as regards the tissues of the uterus and of the fibroid. Prof. Playfair says that the "action of the negative galvanic current in electrolysis is probably simply that of a strong stimulus to absorption." The nutrition of the fibroid can be, and probably is, affected by the current in one, or possibly all, of the following ways: "1st. By affecting the blood vessels and absorbents; 2d. By affecting the muscular tissues; 3d. By affecting the nerves; 4th. By affecting the cells directly; 5th. By affecting the connective tissues."

Had I the time I should be glad to lead you through the experiments that would demonstrate how the current acts upon each of the above tissues; but this case has already taken much more time than I had intended, and I must, with you, be content with its recital. By way of summary, my experience in the treatment of fibroids has been very satisfactory, to put it mildly. I am satisfied that the milder or weaker currents, continued for a longer period (one hundred milliamperes for twelve or fifteen minutes), has a curative action, and is more agreeable and possibly safer than a current of one hundred and fifty or two hundred milliamperes for five minutes or more.

As to frequency of dosage, I am of the opinion that they should be given every other day for a period of three months; then possibly an interval, and the treatment may be resumed once more, the time of symptomatic cure being variable.

I believe also that the intra-uterine treatments, modified as may be necessary, by placing the indifferent electrode, either upon the abdomen or upon the back, so that the tumor may not be outside of the radiation of the inter-polar action of the electrical current, should be thoroughly, persistently and patiently tried before puncture is used. The care of the electrodes is of the utmost importance, to prevent them from becoming the carriers of disease. The

genitals are also to be made scrupulously clean before any form of examination or treatment. My methods with the instruments is to cleanse them in hot water immediately after use, then immerse the metallic parts in pure carbolic acid or Sanitas oil, then give them a hot bath, water to the boiling point, and then immediate drying over a hot plate and return them to a covered case. The hot vaginal injection before and after each treatment is required of each patient.

THE ILLINOIS STATE BOARD OF HEALTH AND THE HIGHER MEDICAL EDUCATION.—Dr. J. B. Lindsley, of Nashville, Tenn., Chairman of the section on State Medicine in the Old School National Society, said in his recent report to that body: "The Illinois State Board of Health has exerted a lasting influence upon medical education by its persistent efforts to protect the people from imposition. Perhaps it is not beyond fact to say that a very few years of legal effort by this single State Board has done more to elevate medical education than all the advisory and hortatory resolutions of our great Association in forty years."

Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

DECEMBER MEETING. 1889.

The regular monthly meeting of the Clinical Society was held in Parlor 1, of the Grand Pacific Hotel, on Saturday evening, December 28, 1889. In the absence of the president, the vice-president, Dr. W. S. Gee, occupied the chair. After the usual routine business the society listened to the report of

THE BUREAU OF CLINICAL HYGIENE.

J. E. GILMAN, M. D., CHAIRMAN.

ON THE PREVALENT EPIDEMIC.—BY DR. J. E. GILMAN—In view of the epidemic of influenza now prevailing all over Europe, and the marked probability of its speedy invasion of America, I thought a brief history of the disorder and its chief characteristics, might be of interest to the Clinical Society.

The history of influenza dates back to the centuries so far in the past that in tracing the course of events the dust of antiquity, and the fogs of ignorance and superstition hide the different diagnoses, and it becomes confounded and lost in the obscurity of the terms that may mean one or another widely differing epidemic disorder. Still it presents an unbroken record of attacks from 1173, when an epidemic swept over Italy, Germany and England, with the well-defined characteristics of what we recognize as influenza. I have examined the records of some ninety-four different epidemics, extending from that date to 1875, and may summarize some conclusions from them.

The disease appears as an epidemic disorder, with a general tendency to travel from east to west, although there

have been variations in some cases from this, and erratic movements of limited area as though conflicting currents of air had conveyed it out of its intended channels. Differing from cholera and allied diseases, the influenza makes its appearance like an avalanche, and not waiting to spread from one individual to another, as contagions are disseminated, this envelops a community with an overwhelming suddenness. Its progress is not gradual, but in great bounds. As though the earth in its voyage through space encountered and attracted within its atmosphere telluric or meteoric dust or gaseous substances that envelope whole countries, extending to continents in its course, and in its geographical distribution sparing no region or latitude. From its very general distribution and utter indifference to temperatures or seasons, we must eliminate from its causation any local origin or influence.

It is ubiquitous, pouring its miasm on lake, mountain, marsh, desert, city or wilderness—winter or summer, in wet or dry seasons, without impartiality. Some epidemics have been of very great severity, as for instance the great epidemic of 1847 and 1848, when one-quarter of the inhabitants of London and fully one-half of Paris were its victims, and all Europe suffered its infliction; while in 1850 and 1851 the United States and South America were also visited, and the epizoötic, or great horse plague of 1872 and 1873 was an analagous disorder to the influenza.

The disease itself presents a considerable uniformity in its course and symptomatology, the intensity of the various symptoms being greater or less in individual cases. Its symptoms and course are a sudden invasion of chill, or chilliness, with naso-pharyngeal dryness and heat, followed by watering eyes, and nasal deflexion, cough, sneezing, sore throat, catarrhal headache, general soreness and aching limbs, bruised feeling, depression of spirits, and a marked debility and sense of exhaustion. There is apt to be a fever, remittent in character, of variable intensity in some cases reaching as high as 104°.

The cough, the soreness, the catarrhal symptoms and the extreme debility are the chief diagnostic symptoms. The catarrhal symptoms begin to disappear on the third or fourth day, but cough and other disturbances may continue for a much longer period, especially if there is any previous weakness of the respiratory organs.

The extreme prostration is one of the longer continuing symptoms, and is entirely out of proportion to the intensity of the fever and the catarrhal derangement, and this makes the disease a dangerous one to aged and infirm individuals, or in cases of organic disease of the heart, or lungs, so that the fatal cases in an epidemic are those with a pre-existing difficulty of some kind.

In uncomplicated cases the prognosis is favorable. I do not mean to be understood that organic diseases of the respiratory organs, or of the heart, must necessarily make the fatal cases, but if there are deaths from influenza there will also be found other complications to serve as the real cause—while the influenza was merely the added trouble that overweighed and broke down vitality.

There have been epidemics that preceded or followed the cholera, but no satisfactory connection of cause, or sequence, has been adduced to connect them, but it is probably more of a coincidence than anything else. Very young infants seem to be less liable to invasion than individuals of any other age, and it has been observed to be intensified in the lowest, dirtiest and most overcrowded parts of towns.

There is no specific for it. I have no doubt that a moderate dose of quinine taken in the initial stage will modify it. Four grains will give enough of tonic stimulus to materially relieve the exhaustion. Aconite or bryonia are the remedies for the fever and bruised feeling, while a spray of ¼ katharmon and 3¼ water will lessen the nasal and pharyngeal discomfort. Allium cepa, or euphrasia, if the sneezing and watery eyes are prominent symptoms. A warm bath at the beginning of the fever followed by rubbing with hot alcohol and salt to secure a good reaction

and sweating, will be a very satisfactory procedure in many cases. Whether the influenza as prevailing in Europe is really present with us or not I am unable to say, but that there is an epidemic of influenza in force here now there is no doubt. In one institution that I know, twenty-five of the clerks are disabled and sixteen of the messenger force unable to fulfil their duties. I have a large number of patients ill and have prescribed for many others, all having symptoms of greater or less severity as detailed above.

Discussion. Dr. C. Gurnee Fellows said: Since the discussion of this disease in the newspapers has attracted so much attention, I am glad to hear Dr. Gilman say that of itself it is not fatal and that the complications may be simply coincident. This is also my opinion, and it seems to me that the opposite idea is creating a false fear in the minds of many. I suppose the Doctor means simply to outline the treatment, but I would like to suggest one or two things concerning it. In addition to the spray of katharmon, which is indeed very good, the alternate use of a spray of quinine (grs. x to the ℥) and a ten per cent solution of cocaine, will, in a short time, allay many of the nasal and pharyngeal manifestations of the disease, or in the very beginning check its development.

In my experience, in addition to the remedies mentioned, nux vomica 1, and napthalin 3, have been very efficacious, the latter for the excoriating nasal catarrh and so many of the other symptoms commonly presented in hay fever.

There is another very useful means of aborting the disease when used in time - a treatment suggested by Dr. S. S. Bishop, of this city, viz.: Take a tablet of morphine 1-2 grain, and atropine 1-100 grain, and divide into halves, quarters or eighths with a pen-knife, and thus we have as low as a sixteenth of a grain of morphine, and the proportional quantity of atropine. Now, it is a clinical fact that the timely administration of one or two doses, or at most three doses of 1-16th grain, will avert many of the attacks of hay fever and influenza.

Dr. Gee: As this is called "The Clinical Society of the Hahnemann Hospital," I am sorry that prominence was not given to the homœopathic treatment. The most severe cases of this disease, in my observation, are those in which quinine was used. It simply retards or suppresses the disease, inviting complications. It is argued by some—but, mark you, never by a man who has made an extensive and pure investigation of drug action, but by men who are more interested in other branches of medical study—that quinine may be given for its "tonic" effect, and that "remedies act just the same," all recognized authority on the use of homœopathic treatment to the contrary.

After grouping the symptoms appearing in a number of cases, it was noticed that gelsemium met the totality, and that remedy has met the symptoms in most cases of this epidemic. The deep aching soreness of the muscles, the restlessness, prostration, headache and catarrhal symptoms are all indications for that remedy. In some instances the headache, soreness of eye-balls and lids and sleeplessness have required belladonna after gelsemium. Eupatorium, perf., nux vomica and rhus tox. meet exceptional conditions. Gelsemium is a good remedy to follow the abuse of quinine.

A long residence in the Wabash valley, participation in the "shakes" of that locality, real experience in the use of quinine and much observation, as well as a critical study of it, warrant me in stating that its virtues are over-rated when used except on the curative law, and the dire results from its abuse are only recognized by those who carefully analyze symptoms, and are prompted to *do no injury* to the sufferer, even if they cannot cure him.

Dr. Lyon. I should like to ask if any of our members have tried lycopodium? In its symptoms and sphere of action it apparently closely resembles the disease as published in the journals and papers. I ask this because I have not seen it mentioned under the remedies adapted, *aconite*, *belladonna*, *bryonia* and one or two others seeming

to be considered as sufficient. These remedies will relieve certain of the more unpleasant symptoms, but I doubt if they are sufficient to effect a cure. Lycopodium and gelsemium correspond more closely with the totality of the symptoms presented in the published cases than any other remedies. Gelsemium has been used with success. Lycopodium has not been tried, as far as I can learn. Lycopodium presents in its pathogenesis the following symptoms, occurring in the present epidemic:

Excessive restlessness, which increases after the patient has gone to bed; pains all over the body, as though it were bruised; worse on lying down, and relieved by motion; severe backache and headache; urine scanty and high colored; vomiting of an extremely bitter, dark-colored matter; hands and feet cold and damp; at times high fever with dry skin, then perspiration; the eyes feel sore and painful; nasal and bronchial irritation, with an appearance of a greater secretion of mucus than actually occurs.

In addition lycopodium is adapted to malarial conditions generally, and especially to the bowel complications of this disease.

Dr. Skiles: Almost every case that I have seen, has been accompanied by nausea and vomiting. I saw several cases yesterday and there was among them no exception to this rule. I do not know whether the experience of others confirms this or not.

Dr. ——: If the temperature remains at 104° for four nights and does not fall below 101° in the morning, is it typical of this disease?

Dr. Gee: No.

Dr. Gilman: I have had one of these patients whose temperature reached 104°.

Dr. ——: I was called to a gentleman who had been feeling indisposed for a week. His temperature was 104°, extremely sensitive to cold, chilliness, fits of suffocation, numbness of the feet which extended to his knees, soreness of the muscles, sore throat, great exhaustion and depression. I applied hot compresses locally which gave imme-

diate relief to the throat symptoms. The temperature was normal the next morning.

Catarrhal symptoms were prominent; delirium and excessive perspiration followed the exhaustion. I gave bryonia for twelve hours, when the patient refused to take any more medicine as he said it caused nausea. His temperature fell to 98° on the last two days.

DR. GILMAN: I believe I mentioned the chilliness. My idea in giving quinine was this: in any malarial condition the exhaustion is best met by the administration of quinine, which is a direct antidote to the malarial poisons. Afterward our remedies come in. At the onset of the attack quinine will relieve the trouble.

I learned years ago in the Wabash Valley, that in the treatment of intermittent fever those who had first received quinine recovered more rapidly than those who were treated with remedies alone. The reason for this is that quinine being a tonic, braces up the system and enables the patient to better resist the disease. This is a matter of observation and experience simply, and I give it for what it may be worth. The continued use of quinine will result in a toxic effect which is not desirable. From two to four grains, if taken at the onset of the attack, will enable the patient to withstand the exhaustion incident to the disease

VOLUNTEER PAPERS.—1. INTUBATION IN DIPHTHERITIC CROUP. BY E. Z. COLE, M. D., OF MICHIGAN CITY, IND.—The prevalence of diphtheria here, this fall, has given me the opportunity of treating seven cases of diphtheritic croup. In six of them intubation of the larynx was performed, but was not permitted in the seventh case. Its success in four of them is convincing proof of its sphere of usefulness. It offers, as also does tracheotomy, the only means of relief in membranous croup and diphtheritic laryngitis, barring any complication that may arise in the course of the disease. The complications met with most frequently are the extension of the membrane into the bronchii, pneumonia, bronchitis, œdema of the lungs, heart

failure, and the toxæmia resulting from the diphtheritic poison. Diphtheritic laryngitis being so rapid in its course, as also is membranous croup, valuable time is often lost in the administration of and sole reliance upon medicines. But by intubation of the larynx the impending stenosis and dyspnœa can be prevented. Then remedies, as the indications call for them, can be often given with good results. If intubation should give no relief, and the membrane is forming still lower down, then tracheotomy becomes the last resource.

My experience in other cases, and in the seventh case as reported, convinces me that our remedies may do well in mild cases, but that in a typical case you might just as well shut your eyes, open your medicine case and take the first bottle that comes to hand. But when the tube is in situ, and the dangers of asphyxia are over, and the dyspnœa is relieved, then our remedies are indispensable. Assisted by Dr. W. J. Truitt, I have recently intubated six cases of diphtheritic laryngitis. Four of these cases fully recovered, and two died from diphtheritic toxæmia.

Case 1. I was called, on the morning of November 15, to see Chris. T., aged 11, and found that the boy had been croupy for the previous two days. Dyspnœa had commenced the evening before, and was gradually getting worse. As there were good indications for kali bich., that remedy was left for him. Calling two hours later, I found no improvement, but the dyspnœa worse, and the boy rapidly becoming cyanotic. With the consent of the parents, I inserted O'Dwyer's largest-sized tube. Marked relief in the breathing was immediate. Great quantities of mucus were now expectorated by coughing, which gave still further relief. The next morning the tube was expelled by coughing brought on while he was drinking milk. It was replaced, but fifteen minutes later it was again coughed out, followed by a large amount of ropy, stringy mucus. This gave such marked relief that the tube was dispensed with.

On the evening of the 17th, however, I was hurriedly summoned and found this boy in a critical condition. The dyspnœa was extreme, with deep sinking in of the lower end of the sternum, and the surface was extremely cyanotic.

I inserted the tube, with immediate relief. On the 18th it was again coughed up, but was not again replaced, and the boy made a good recovery.

Case 2. Nov. 21 was called in the evening to Fred H., and upon examination found pharyngeal diphtheria and extension of the membrane into the larynx. The dyspnœa was pronounced. I desired to intubate, but the parents objected. The next morning I was sent for and requested by the parents to intubate. The dyspnœa had become extreme, and the boy was cyanotic. The effort to breathe during the night had weakened him considerably. The insertion of the tube gave almost magical relief to the breathing. He continued to do well, when, on the fifth day, I removed the tube, and he made a good recovery. One very noticeable feature about this case was his ability to swallow liquids without any trouble while wearing the tube.

Case 3. Nov. 24th, Fred T., brother to case 1, aged 7. I had been treating him for pharyngeal diphtheria since Nov. 19th. He began to be croupy on the 23d and his breathing became difficult that night. He gradually grew worse on the 24th, and, being detained elsewhere, when we reached him that evening we found him in a comatose condition almost pulseless, cyanotic and perfectly limp. The case seemed hopeless but the tube was inserted, with a gradual relief to these dangerous symptoms. The next morning he was breathing quietly and easily. But about 4 p. m. of the next day the tube was expelled. His breathing becoming worse, we attempted to reinsert the tube but the boy struggled so that we had to desist. Two hours later, being hurriedly sent for, upon reaching there was met by parents at the door, who exclaimed: "Doctor, it is too late, he is dying." Although afraid that it might be too late, I inserted the tube and was surprised to see the boy rally. The tube was again expelled the next morning and reinserted two hours later. He continued on, with complete relief from the dyspnœa, but died on Dec. 2d from diphtheritic toxæmia. The membrane covered the pharynx, the fauces and the entire buccal cavity, making a most malignant case of diphtheria.

Though this case died, yet the intubation, from the relief it gave, was a decided success and prolonged his life, he dying quietly thirteen days from the commencement of the disease.

Case 4. Nov. 24, Arty T., brother to cases 1 and 3, age 15 months. Dyspnœa began in this case about the same time as in case 3. He was becoming cyanotic, when, at the urgent desire of the parents, and after tubing case 3, I succeeded after considerable difficulty in introducing the smallest sized tube. In five minutes afterward the child was sound asleep. The tube was expelled the next day at 5 p. m. and reinserted an hour later. The child continued doing well, when, on Nov. 27, I removed the tube, it having been retained for five days. But the symptoms returning, I was compelled to reinsert it four hours later. The tube was again removed on Dec. 3, the child having worn it nine days, with the exception of about five hours. The child has made a good recovery.

This case was one of primary laryngeal diphtheria. The membrane afterward formed on the fauces, and on the gums, and cheeks, where it had been lacerated by the use of the mouth-gag.

Case 5. Willie M., age 8. This case came into my hands Nov. 30, after another physician had given it up as hopeless, and after a treatment of four days. The dyspnœa had weakened the boy, and he was plainly suffering from the diphtheritic toxæmia, making it a hopeless case to save at the late day in which I was called. More to relieve the dyspnœa, as the parents desired something done, I intubated. The breathing immediately became easier, but the boy became extremely delirious, being held down with difficulty. He quieted down, and in half an hour from introducing the tube he became conscious, recognizing those about him. He remained so about fifteen minutes, when he suddenly collapsed. Only after persevering efforts at resusitation for five hours were we rewarded by the boy beginning to breathe naturally. Two hours later he was conscious, breathing quite easily. At times he would be delirious, requiring to be held down, and then afterward relapse into quiet sleep. He gradually weakened and died quietly, Dec 2d, from diphtheritic toxæmia.

There was no prospect of saving this case, but I do believe, could I have intubated the first twenty-four hours of the disease, when, to be successful, intubation should be done, I should have saved it.

Case 6. Dec. 14, 1889. Martha T., age 4, a sister to cases 1, 3 and 4, made the fourth case of laryngeal diphtheria in this family. She began to be croupy on the 11th,

and was put at once under medicinal treatment in the hope of curing the disease without resorting to intubation. But she grew worse and suffocation being imminent, a tube was inserted with immediate relief. It was coughed up the following day with the result of bringing up a partial cast of the larynx. The tube was replaced a few hours later, being assisted this time by Dr. Calvert, of the Northern Indiana Prison. The tube was again coughed up on each of the two successive days, being followed by profuse quantities of mucus each time it was removed, making in all four insertions of the tube. It was finally coughed up on the 19th, and as the child seemed to be breathing easily and able to get the mucus up it was not replaced. She has made a good recovery.

We had in this case the same difficulty experienced in the other cases in this family namely, the coughing up of the tube. Considering the immense amount of mucus each case would succeed in bringing up I think the explanation is simple, being a clogging up below the tube, and at times of the tube itself, by the membrane and secretion. The remedy I relied on in this case, and from which I perceived marked benefit was *kali mur.*

Case 7. The seventh case was one of primary laryngeal diphtheria in a child seventeen months old. Three of the older children of the same family had previously been under treatment for pharyngeal diphtheria. The parents were informed as to outcome of the case, and intubation was proposed as the only means of saving the child. This they would not consent to, and so medicinal measures were resorted to in the hope of saving the child. The progress of the disease was rapid, being of three days' duration, the child dying on Dec. 24.

My past experience bears me out in saying that this child could have, in all probability, been saved, had intubation been performed. The remedies which I have employed have been *aconite, bromine, hepar sulph., iodine, kali bich., kali mur., and spongia.* Steam was kept continually going in the room, iodine being added to the water. Sprays of solutions of *iodine, bromine, peroxide of hydrogen*, and *merc. corr.*, were found to be valuable auxiliaries.

2. COCAINE IN THE MORNING SICKNESS OF PREGNANCY. By W. A. MIRICK, M. D., OF MONTICELLO, IOWA. The value of this agent in the relief of the distressing and intractable

vomiting of pregnancy may not be known to the readers of THE CLINIQUE, and the following cases are therefore presented:

Case 1. Mrs. Blank carried her first two children to term without nausea or vomiting, except at the beginning of gestation. In four pregnancies following, however, she had such severe and uncontrollable vomiting as to induce a miscarriage at about the third month in each case. Having a relative who was an excellent physician, she had his advice and aid and that of several of his brother practitioners, but all that they could do for her relief, even to cauterization of the uterine cervix, was of no avail.

In her seventh pregnancy she first consulted me at about the eighth week. I tried the usual remedies but without benefit. She vomited almost incessantly day and night, and the ptyalism was copious and constant for another month. I then gave her, at evening, a hypodermic injection consisting of ten drops of a four per cent. solution of cocaine. That night she slept well, and the uterine pains which had threatened as before to result in a miscarriage, had ceased and she felt greatly relieved. The next morning I repeated the hypodermic and she ate her dinner, enjoyed and retained it. For a week longer she had the same dose night and morning, and then for three weeks took it only at night. We found that its use had to be continued in this way else the symptoms would return. After that she did not need it. There were no physiological symptoms, and she went to term and was finally delivered of a sound, healthy child.

Case 2. Mrs. X., had had one miscarriage in consequence of intractable vomiting. I saw her in consultation at the sixth week of her fifth pregnancy, after the physicians had exhausted almost every known resource, and had seriously considered the propriety of ending her suffering by emptying the uterus of its contents.

I advised a trial of the cocaine, and it was resorted to, but the first two applications seemed to have no effect, probably because the preparation of the drug was not

fresh. We then made a five per cent. solution, of which fifteen drops were given. This developed a slight poisonous action, for she had slight tonic spasms, which came on in two minutes after the hypodermic was given, but which disappeared in five minutes more. There was also temporary loss of consciousness. After this she ate and retained her dinner the same day. In the evening she received fifteen drops more with the same physiological and remedial effect. From that time only ten drops were given, as in the former case, and the relief was complete and permanent.

Case 3. Another woman in her second pregnancy, at about the sixth week, began to have morning sickness, but because she wished to keep it from the neighbors and friends, said nothing about it for a week or more. She vomited after every meal, and between times, every two hours or so, and had constant nausea with free ptyalism. I gave her ten drops of a four per cent. solution of cocaine, by the mouth, at bedtime. She slept all night, and about half an hour before rising in the morning she took, by my direction, ten drops more in the same way. She ate her breakfast and did not vomit that day. The nausea had almost entirely disappeared. From that time on, for four or five days, she took it once a day, and always before rising in the morning, and afterward only occasionally, when she felt it to be necessary. It always gave prompt relief.

3. TWENTY GYNECOLOGICAL CASES TREATED BY MASSAGE. —Translated and condensed from Vulliet, by DR. F. W. ROBINSON. (*Continued* from Vol. x, page 449.—*Case 11.* Madam R., 40 years old, menstruated at 14; had dysmenorrhœa from the beginning, with a tendency to metrorrhagia. She had her first child when 27 years old, the labor being normal, and the second at 28. Abnormal leucorrhœa a month later, which continued from this time on, accompanied with both metro—and menorrhagia. At 31 years her first miscarriage, occurring at two months and a-half; at 33 her second do. also occurring at two and a-half months. These miscarriages could not be attributed to any external violence. The hæmorrhages which had persisted ever since the first normal labor, became still more intense since

the occurrence of the second miscarriage. A few months later the pelvic pains made their appearance.

At the age of 34 she was the victim of a sudden attack of acute peritonitis, which confined her to her bed for four months, and placed her life in great danger. From this time there began a new era, for the inter-menstrual hæmorrhages ceased and the periods, though returning each month, diminished constantly, both in duration and abundance. However, the abdomen remained painful, and from time to time there occurred attacks of acute inflammation. At 35 the menses ceased entirely, but her general condition was wretched, she being feeble and nervous, troubled with a cough, nausea, violent pains on passing water, which she was compelled to do four or five times in the night and every half-hour throughout the day. This condition of affairs lasted for three years, during which time the abdomen kept increasing in size up to a certain point, when it would become small again, only to repeat the same process a short time later.

She finally consulted Prof. V., who found the following condition of affairs present: The patient is of large size and emaciated; facies uterina strongly marked; agitated and talkative; is a morphomaniac; the abdomen is as large as at the seventh month of pregnancy; the lungs, heart and kidneys are healthy.

On palpating the abdomen, one recognizes the existence of a tumor, situated in the median line, reaching up to a point three finger's width above the umbilicus and extending laterally as far as the pelvic walls. The mass was, as a rule, flat on percussion, having distributed over its surface, however, occasional areas of resonance. The uterus pressed forcibly forward against the pubis. Sharp pains were caused by pressing against the rectum and bladder. The womb was too much compressed to determine whether it is attached to the tumor or not. Rectal exploration revealed the fact that it was pressed almost flat at a distance of five centimetres above the anus.

There was evidence of numerous adhesions existing between the tumor and the various organs of the pelvis, as well as the intestines.

Dr. V. felt justified in considering the tumor of inflammatory origin, and resolved to try the effect of massage in the hope of liberating the various organs, bound together as they were, by adhesions; and of exerting a favorable influence upon the morphomania. Every morning external

massage, for six minutes, followed by a friction of mercurial ointment, and the application in the vagina of a cotton tampon charged with iodoform and belladonna ointment. In the evening a cloth, wrung out in cold water and carefully covered over with another to prevent evaporation, was to be applied to the abdomen.

2d day. The patient supported the operation better and the massage was continued for eight minutes.

3d day. The abdomen is much more pliable. The massage was repeated in the evening and the bandage applied afterward.

The patient, for the first time since the attacks of peritonitis, was obliged to get up but once, to urinate. The bowels now move of themselves, whereas, formerly, an enema was always required to open them.

4th day. The treatment caused severe pain and therefore during the next day the patient was allowed to rest. The treatment was continued for nine days, when the tumor was found to reach only as far as a point two finger's breadth below the umbilicus. It had also grown smaller laterally and a marked separation existed between the tumor and the intestines, which before had been firmly united together.

The massage treatment was continued for a month longer, at the end of which time the tumor reached but four finger's breadth above the pubis and was free at all points.

It was divided into two parts by a furrow situated in the median line, on both sides of which fluctuation was distinctly to be made out, and was now pronounced to be made up of tubo-ovarian cysts, resulting from the closure of the fallopian tubes by inflammation. They were punctured and several litres of a white albuminous liquid was drawn off, after which they collapsed. The uterus was now but little over the normal size and completely mobile. The massage was continued for five weeks longer, at the end of which time the patient was entirely cured. The functions of the rectum and bladder were restored and the patient walked without the slightest difficulty.

It must be acknowledged that this case was not cured by massage alone; at the same time, had it not been for massage, a laparotomy would have been the only resource, and taking into consideration the numerous adhesions of the tumor, and the cachectic state of the patient, together with her habit of taking morphine, it is hardly possible to

suppose that the operation, had it been performed, would have resulted successfully.

Case 12. Mrs. W., of 51 years, had fungous endometritis, laceration of the cervix and perinæum, and prolapse of the uterus. Curage and trachelorrhaphy, which healed by the first intention. For twenty-one days, massage and elevation of the uterus. Complete cure; eight months afterward she remained well.

Case 13. Mrs. T., 24 years old, with stricture of the internal os-uteri, anteflexion, dysmenorrhœa, endometritis and leucorrhœa. Catheterization of the uterus. Massage and uterine gymnastics. The womb is bent back several times a day in retroflexion. Cure in three weeks.

Case 14. Madame M., æt. 49, had a right-sided parametritis. Interstitial fibromata of the posterior wall. Metritis and perimetritis. The uterus was firmly wedged in the hollow of the sacrum. For eight days, massage for the parametritis, and dilatation of the uterus, which led to the discovery of the fibromata. The parametritis disappeared, the uterus became movable, and was in its normal position. The dilatation caused a cessation of the metrorrhagia, which had formerly existed. The patient was seen again thirteen months afterward, and the cure was still maintained.

Case 15. Madame D., 42 years old. Diagnosis: Had a double laceration of the cervix, ruptured perinæum, chronic-metritis and pelvic peritonitis. Tait's operation for lacerated cervix was first performed; then she had pelvic and uterine massage for eight days, when she left the clinic cured.

Case 16. Madame N., Swiss, 50 years. Diagnosis: A doubly lacerated cervix and a torn perinæum, with endometritis and metritis and prolapse of the uterus. Curetting of the uterus was first performed; then Tait's operation upon the cervix. After this, uterine massage and elevation for seventeen days, resulting in a complete cure.

Case 17. Mrs. M., Swiss, 42 years old. Had complete prolapse of the uterus, combined with difficulty in passing water. There was also hypertrophic elongation of the womb, its cavity measuring twelve centimeters. No rupture of perinæum. The complete prolapse had already existed for a month.

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Hospital Notes.

THE EYE AND EAR CLINIC.

SERVICE OF PROF. WATRY.

Case 1. Hyperæmia of the conjunctiva. Nov. 19, 1889. A female patient, 22 years old, complained about her eyes having troubled her for the past year. The eyes felt feverish, and at times smarted. The most annoying symptom, however, was a blurring sensation on attempting to use the eyes. The patient could see to read the finest print, and was able to make out 10-10 of Snellen's test-type.

On inspecting the eyes there was noticed a slight congestion and thickening of the caruncula, and the semi-lunar fold was somewhat swollen. On everting the lids the conjunctiva presented a bright-red appearance, instead of the usual rose color. The lids never glued together at night, but occasionally there has been a little matter in the corners on awaking in the morning.

Prescribed tannic acid gr. jss, glycerine ℥ss, dist. w. ℥j, to be used twice a day, two drops each time. Gave no medicine to take internally.

Dec. 3d. Reported very much better. The blurring had almost left entirely, and the eyes felt more natural than they had for a long time. Same treatment.

Dec. 17. No more blurring. Can now use her eyes without reminding her constantly that there is something wrong. She was instructed to use the drops once a day for another week, and in case the eyes did not feel well at the end of two weeks to report again.

Case 2. Sympathetic inflammation caused by injury. April 2, 1889. A Swede, 25 years old, was sent to the clinic from Wisconsin. He gave the following history: On the last day of January, while walking from the field into the woods, he had to climb over a fence; on jumping down he happened to strike a small limb with his left foot; the branch flew up and accidentally struck him in the right eye. He put his hand quickly to the eye, and felt the escape of quite an amount of a watery substance. There was but very slight bleeding. The sight was almost completely

destroyed. Pain began to set in shortly after the injury, and despite the medical treatment he received, the eye swelled, and the pain became excruciating for several weeks, after which it began to subside, but has pained him more or less up to the present time. About three weeks after the accident the left eye began to feel weak. The eye became sensitive to the light, and looked congested. One week later the sight began to fail, and had been gradually decreasing.

A local examination of the injured eye revealed a staphylomatous condition of the upper and outer portion of the globe. A line of cicatricial tissue ran through the ciliary region, encroaching well on the cornea and the sclera. The cornea was hazy, the iris congested and swollen. The area of the pupil looked greenish-yellow, and a distinct hypopyon was present. The pupil was very irregular, caused by prolapse and incarceration of the iris. There was no perception of light. The comparatively good eye presented a very congested appearance. There was turbidity of the aqueous humor, and inflammation of the iris, with contracted pupil. The sight was so impaired that the fingers could be counted only at three feet. Owing to the turbidity of the humor it was impossible to examine the eye with the ophthalmoscope. The patient was put under an anæsthetic, and the injured eye-ball removed. This was rather difficult, on account of the inflammatory adhesions which had taken place between the sclera and the outer tissues. The hemorrhage was somewhat more profuse than usual, but was controlled with ice. The usual antiseptic precautions were observed in bandaging. The patient was put in a dark room, and a three-grain solution of atropia was instilled in the sympathizing eye three times per diem. Gave bell. 3. The patient experienced no pain from the time of the removal. Ten days later he went home with a vision of 10-70. The aqueous had cleared up and the pupil was thoroughly dilated. The ophthalmoscope showed congestion of the optic disc. He was instructed to wear very dark-colored spectacles, and to drop atropine in the eye once a day for a few weeks longer.

Case 3. Myopia causing headache. Nov. 20, 1888. The patient, a strong, healthy woman, complained of poor eyesight. She had had weak sight as long as she could remember. Has been troubled with a constant, dull, heavy pain in the forehead for many years. This pain almost

always grew worse after prolonged use of the eyes. Vision in the right eye was $\frac{5}{200}$ and not quite as good in the left. The ophthalmoscope showed a large posterior staphyloma in both eyes and a chronic choroido-retinitis which, according to all appearances, had run its course. A — 8 D raised vision in both eyes to $\frac{10}{20}$ and with a — 3 D she was able to read ordinary print at about 10 inches. Gave her a prescription for two pairs of spectacles, — 3 D for near and — 7 D for distance.

As most of these cases have more or less spasm of the ciliary muscles, a — 1 D was taken from the actual strength of the glass which the patient accepted. The patient reported four weeks later. She had been wearing the glasses constantly with a great deal of comfort. The headaches had considerably decreased in severity, and she felt positive that the glasses would soon relieve them entirely.

Case 4. Triderœmia. A young girl twenty years of age and of a very light complexion, came to find out if anything could be done to improve her eyesight. The sight had always been very poor. Bright light dazzles very much and makes the objects appear dim and confused. The eye-balls presented the appearance as though the pupils had been dilated with a strong mydriatic. On closer inspection under oblique illumination it was observed that there was almost complete absence of the iris. Stenopaic spectacles were tried but did not improve the sight, and as she was already supplied with colored glasses, she had to be informed that the weakness of sight was due to a congenital abnormality, and that nothing could be done.

Case 5. Corneal ulcer. Nov. 8, 1888, May, aged fourteen, complained of severe shooting pains through the eyeball. Photophobia and lachrymation were quite marked. On opening the lids there was noticed a small infiltration near the center of the cornea, surrounded by an effusion of lymph. The pupil was contracted and a bright circumcorneal congestion was present. Prescribed a three grain solution of atropia sulphate, to be used three times a day, put on a protective bandage, and gave calcarea carb. 3. One week later there was no more pain. Healthy granulations were filling up the depression at the seat of the ulcer. The congestion and irritability were much diminished. Same treatment continued. In another week the ulcer was healed and the eye felt much stronger. Ordered colored glasses and atropia once à day.

Dec. 4. The patient was discharged from treatment with a slight opacity which interfered but very little with vision.

Case 6. Phlyctenular keratitis and catarrhal conjunctivitis.—Aug. 9, 1889, a girl three years old was brought by her mother to have the eyes treated. The mother stated that the girl's eyes had been sore for nine months. During that time the child had received three months' treatment. The photophobia was so intense that she would not open the eyes for days together. Some mornings the lids were slightly stuck together, then again there was no discharge for days. The examiner took the child's head between his knees in order to get a good look at the eye-balls. There were scattered several pustules and small specks of infiltration over the surface of the cornea, which were nourished by numerous little blood vessels with their characteristic apex and base, the apex touching the infiltration. There was an intense redness around the cornea, and the palpebral conjunctiva was swollen and very congested. There was a profuse discharge from both nostrils, accompanied by swelling of the upper lip. Prescribed a four-grain solution of atropine. Painted the nostrils with a two per cent solution of argentum nit., and gave calcarea carb. 3.

One week's treatment made no perceptible change toward improvement. The pupil was thoroughly dilated but the congestion and irritability were about the same. Used powdered calomel and prescribed arsenicum 3.

Aug. 24. The child took a cold; slight muco-purulent discharge; painted the everted lids with a three-grain solution of arg. nit., followed by atropine. This treatment was kept up, and on Aug. 30th there was a marked improvement. The cornea began to clear up, and the blood vessels were undergoing obliteration. Same treatment.

Sept. 6. Had taken another cold; eyes worse; slight corneal opacity in the right eye, and a small corneal ulcer in the left. Used atropine and gave mercurius cor. 3.

Sept. 8. The corneal opacity had cleared up somewhat and the ulcer was about the same. Continued the same treatment. The eyes improved slowly.

On Sept. 15th argentum nit. was used in connection with the atropine. This treatment was kept up to the 6th of October, with a very good result to both the cornea and the conjunctiva.

As there was no more discharge from the conjunctiva, the argentum was replaced by the powdered calomel. There was a slight eczematous eruption of the face, for which graphites was given. Another three weeks' treatment with calomel and atropine locally cured the case.

Case 7. Acute suppurative inflammation caused by injuring the drum-head.—Feb. 19, 1889. A young, healthy-looking servant-girl, was eating apples with her friends a little less than a week ago, and they amused themselves by throwing the seeds at each other. Accidentally one of the seeds was thrown into her ear. The next day she consulted a physician, who attempted to remove the foreign body. The operation was accompanied by considerable pain and slight bleeding. The pain has grown worse since, and the hearing become very much impaired. A local examination with the mirror and speculum revealed a round, central perforation of the drum-head about the size of a small split pea. The congestion of the drum membrane was marked, and the tympanic cavity was filled with a muco-purulent discharge. The tick of the watch could be heard only at five inches instead of thirty-six. The ear was inflated and cleansed, and the patient instructed to use dry heat, by heating cotton-batting in the oven and tying it over the ear, and to keep it clean by syringing it out once a day. Hepar sulph., 3.

After this treatment had been kept up for one week the patient reported that the pain had decreased shortly after the heat was applied. The discharge was but scant, and the perforation somewhat smaller. The ear was again inflated and thoroughly cleansed. Applied boracic acid powder, and she was directed to take the medicine twice a day.

March 12. Had a little shooting pain now and then. The discharge had almost stopped, but the perforation was no smaller. The following week there was no more discharge, no pain, hearing better, perforation the same. Ordered the syringing to be discontinued and gave calcarea carb. 3.

April 9. Hearing improved, perforation the same. Irritated the edge of the perforation with a four per cent solution of argentum nit. Two days later the perforation was slightly smaller. Repeated the same treatment.

April 18. No change in the size of the perforation. Hearing very good. Freshened the edge of the opening with a narrow-bladed cataract knife.

April 25. Perforation healed. From this time on up to the 16th of May there was no other treatment besides inflation. The hearing was normal, and the patient was discharged with a slight opaque spot at the seat of the perforation.

Case 8. Chronic suppurative inflammation, with polypus in the tympanic cavity. Dec. 18, 1889. A little girl, only 12 years old, but quite intelligent, said that four months ago her left ear began to discharge without the slightest provocation of pain. The discharge was of a thick, creamy character, and very offensive. After the ear had been syringed, it was found that two-thirds of the membrana-tympani was destroyed, and that a polypus about the size of a pea was situated in the tympanic cavity. The hearing was 3-36. The patient was told to have the ear syringed out once a day, and to use locally, three times a day, ten drops of a solution of rectified spirits of alcohol ℥j to water ℥jss. Calcarea carb. 3 internally.

Jan. 3d. There was less discharge, the polypus was smaller, and no odor. The ear was cleansed and inflated. The same treatment.

Jan. 17. The discharge was very slight, the polypus reduced about two-thirds. Same treatment.

Feb. 5th. There was no discharge, the polypus had withered, and after inflation the hearing was 15-36. Prescribed boracic acid powder to be used once every other day. The patient did not return.

Case 9. Closure of the Eustachian tube. Dec. 4, 1888. A woman, 29 years old, caught cold a few weeks ago, which affected her nose and throat. The next day the ears felt muffled, and she had sharp, shooting pain, with a continued cracking, buzzing noise in both of them. The buzzing continued for three days, then gradually began to subside. Her own voice had a natural sound, although there was considerable fullness in both ears. There was a sharp, shooting pain, especially in the right ear. The hearing in the right ear was 5-36, and in the left 20-36. Used Politzer's method of inflation, with an astonishingly good result. The hearing was again tested, and found to be in the right ear 18-36, in the left ear 24-36. Prescribed bell. 3.

Dec. 6th. The patient reported a marked improvement. Used inflation, and continued the same medicine three times a day.

Dec. 11. Had not a stitch of pain for the last few days;

no more fullness. Same treatment. One week later the patient's hearing was almost normal in both ears.

Case 10. Chronic suppurative inflammation of one, and chronic non-suppurative inflammation of the other middle ear. Jan. 15, 1889. A twelve-year old girl was brought to the clinic by her mother, who stated that her daughter had been troubled with a discharging ear for over eight years. As near as the mother could remember the discharge dated back to the time when she had measles. The hearing in the other ear became impaired within the last year. The discharge was very profuse and purulent in character, the drum-head was entirely destroyed and the hearing reduced to $\frac{1}{36}$. The left drum-head was somewhat opaque and sunken and the hearing for the watch was $\frac{10}{36}$.

The suppurating ear was syringed out and dried. Inflated both ears with Politzer's air-bag. Insufflated boracic acid powder in the tympanic cavity and prescribed hepar sulph. 3, three times a day. The patient was instructed to keep the ear clean by syringing. Two days later she received the same local treatment.

One week later the discharge began to diminish, and on Feb. 5th the patient reported no discharge. Ordered the ear to be syringed out every other day. Hepar sulph. 3 once a day.

May 28. Patient took a cold a few days ago which brought on a slight discharge. Cleansed the ear, used inflation, gave belladonna 3.

June 6. The discharge is hardly noticeable; continued the same local treatment with hepar sulph. 3. One week later there was no more discharge. The hearing had improved somewhat in the right ear, while in the left it was almost normal.

June 20. No discharge and the hearing is quite good. Patient did not return.

Case 11. Chronic suppurative inflammation of the middle ear caused by injury. Oct. 9, 1889. Over two years ago a young woman 19 years old, accidentally ran a knitting-needle into her right ear. It caused some pain at the time, which soon ceased. Three days after the injury a profuse muco purulent discharge set in, which soon became purulent in character. The discharge has been constant ever since.

The drum-head was almost entirely swept away. The mucous membrane in the tympanic cavity looked very congested, swollen and granulated. After the ear had been

cleansed in the usual manner the granulations were touched with a twenty-grain solution of arg. nit. The patient was instructed to syringe the ear once a day. Prescribed peroxide of hydrogen to be instilled twice a day.

Nov. 1. The discharge was not so thick and purulent but still was quite profuse. Used the same local treatment.

Nov. 29. Had not improved much. Prescribed arg. nit. twenty grains to one ounce of water—five drops of this to be instilled twice a day. This, in connection with the local treatment which the patient received at the clinic as above stated, had a very good effect on the granulations.

Jan. 10. The discharge was very slight. Prescribed two parts of alcohol to one of water, to be used once a day.

Jan. 24. There was hardly any discharge. The granulations had undergone absorption, the mucous membrane looked smooth and but slightly thickened. Used boracic acid powder locally. The same treatment at home as before.

Jan. 29. She reported that she took a cold which settled in her ear. There was a great deal of pain, and the mastoid region was tender and swollen. Ordered cold applications over the mastoid region, and prescribed capsicum.

Feb. 5. The tenderness over the mastoid was all gone, no pain in the ear, some discharge. Prescribed a ten per cent solution of peroxide of hydrogen. No medicine internally. The ear kept on improving, and the patient was discharged from treatment during the month of March.

Clinical Reviews.

CONGESTION OF THE LUNGS AND ITS DANGERS—BY THOMAS NICHOL, M. D., LL. D., D. C. L., etc., etc. Montreal Tracts on Homœopathy, No. 6. Montreal, 1889.

It is not often that the chronic reader of current medical literature is rewarded for having to wade through a pile of "stale and unprofitable" matter by stumbling over some bit of refreshing thought. It's a long lane that has no turn, however, and it was my luck to have pointed out to me a brief pamphlet due to the pen of an estimable Canadian *confrère*, Dr. Thomas Nichol, of Montreal, under the title of "Congestion of the Lungs and its Dangers." The author has a well-established reputation as a careful and successful practitioner and as a scholar, but even were he totally unknown outside of his own street or city, the little tract above mentioned would suffice to stamp him as a medical man of real worth. There is more clinical import in these few pages, couched in a simple, discursive, unpretentious style, than could be found in some ponderous works of recent German manufacture that I know of.

The author introduces his theme by marvelling at the utter disregard that this subject of "congestion of the lungs" has met at the hands of the most authoritative and popular medical writers, both of the old and of the new school, in this country and in Great Britain. He shows that not one of the accepted text-books has a word to say about it, and that one must fall back on French literature in order to get some information on this much-neglected topic.

He frankly acknowledges that Andral was the first to describe the general character of congestion of the lung as far back as 1829, and that, at a later date, another Frenchman (Woillez) furnished the proof that congestion of the lungs produces an enlargement of the chest that is clinically appreciable.

It is more praiseworthy than it at first appears for an English mind, nurtured on Anglo-Saxon and Teutonic pabulum, to have gotten rid of inborn prejudice, and to have found its way to a true source of information, even when that source is Gallic.

Moreover, at a time when the prevailing influenza causes so many dangerous determinations to the pulmonary apparatus, it may not be devoid of interest to study some of the vascular perturbations that are apt to arise in such profusely irrigated organs.

It is quite interesting to observe how the notion of active congestion of the lungs, as a morbid entity, entirely different from pneumonia, happened to dawn on the candid and searching mind of the author. Here are his own words:

"When I commenced practice, I knew nothing at all of congestion of the lungs. I had a fair knowledge of congestion in general, and also of congestion of the brain and other internal organs, but of pulmonary congestion I was grossly ignorant.

"Soon after, a medical friend, now deceased, belonging to the dominant school, requested me to see a case of his in consultation.

"The patient was a strong, athletic man in the prime of life, who had been suffering from *delirium tremens*, but who was now convalescent, at least from that disease. He had carelessly gone into his garden, insufficiently clad, and had evidently taken cold. We found him with a weak, fluttering pulse, cool skin, covered with cold sweat, cold extremities, difficult breathing, muffled cough. On examining, we found that scarcely any air entered the lungs, while the tired heart tried in vain to propel the blood through these organs. It was an entirely new case of morbid state to me, and my friend, who was my senior, admitted that he had not noted it before. We turned the case thoroughly over in our minds in the light of physiology and general pathology, and came to the conclusion that the lungs were completely dammed up with blood; that, in fact, the man had congestion of the lungs. My friend prescribed according to the light we had, but the man died in spite of very close attention. We looked up all the books and journals in our libraries, but found no ray of light from what was really a good collection of medical literature."

The doctor goes on narrating how, having subsequently come in contact with analogous cases, congestion of the lungs became to him "a well-recognized morbid state, calling for a well-defined treatment, and eminently responsive to that treatment."

As to the Doctor's graphic description of the symptomatology of pulmonary congestion, it tallies to a nicety with

that given by the French clinicians. The abrupt invasion, sometimes preceded by a chill, the thoracic pain, mostly infra-mamary, the slight and ephemeral fever, the dyspnœa often out of all proportion to the frequency of the pulse and the height of the temperature, the scanty cough, often entirely absent, the grayish transparent sputa, *feeble breathing* at auscultation. Such are the characteristic phenomena of moderate congestion of the lungs. Of course in the violent cases the scene is somewhat different, as symptoms of collapse and asphyxia are apt to develop with a frightful rapidity.

Such fatal cases are not extremely unfrequent, and it must be borne in mind that prolonged exposure is by no means the only cause for their occurrence. Severe over-exertion, bodily and mental, is quite likely to bring about a similar result. Violent emotions are another source of danger, anger especially, whereas grief is more likely to cause hepatic congestion.

I shall never forget the case of Ch. P., a class-mate of mine, a bright young man of decidedly neuro-sanguine temperament. One day, after a violent fit of passion, he fell suddenly ill. When I saw him I felt that he was in mortal danger. His flushed cheeks stood in strong relief against the lividity of his nose and lips, the pulse was rapid and thready, while the dyspnœa was such that I was unable to keep track of the respiration. In less than 24 hours all was over, in spite of every effort of the old-school practitioner who attended him. Cases of sudden death occasionally occur among women in the puerperal state that might be traced to pulmonary congestion, and every degree of hemorrhage has been observed as a result of the congestive process.

As to the physical signs they are singularly mobile and variable. Percussion gives little satisfaction. In auscultation we may find some sibilant, at times some fine bubbling rales, but as a rule moist rales are unfrequent, except in those cases where congestion is accompanied by œdema.

Feeble breathing, as pointed out by the author, is ordinarily the only stethoscopic sign available. As a matter of fact the only reliable physical sign is the one afforded by mensuration, which is so thoroughly studied by Woillez. If in any case of suspected congestion we take care to practice mensuration at the level of the zyphoid appendix with a simple tape, we will be surprised to find that in the course of 24 hours, or even less, the fullness has fallen off

in a notable degree. This, of course, fixes the diagnosis, as no other pulmonary disease could bring about such a change in so short a space of time.

It is to be regretted that the author, who evidently knows of that precious sign, should have nothing to say about it. We cannot, however, too highly commend the way in which he draws a sharp line between this congestion and pneumonia. "In pneumonia the access of the disease is graduai, while in congestion the attack is sudden. In pneumonia cough is frequent and constant; in congestion it is at all times slight, and is often entirely absent. In pneumonia the expectoration is somewhat scanty, plum-colored in hue, and tenacious; in congestion it is transparent and only occasionally tinged with blood. The fever of pneumonia is marked by a high temperature, rarely under 105°; that of congestion is evanescent and rarely exceeds 102°. Lastly, in pneumonia the signs obtainable by auscultation are almost invariable; in congestion they vary almost infinitely."

Following up the comparison to the post-mortem table, we beg leave to state that the hyperæmic lung, however engorged it may be, *can always be insufflated*, which does not obtain with the pneumonic lung. The author forgets to say that the only other affection with which congestion could be confounded is pleurodynia, both on account of the thoracic pain and of the benignity of the attending symptoms. But the error will be easily avoided by remembering that pleurodynia is totally apyretic and does not affect the integrity of the breath-sounds.

Now, besides the fatigue of the vocal organs mentioned by the authors, there are many etiological factors of active congestion which Dr. Nichol does not mention, among which are the chill of ague, the suppression of the menses, or of the hæmorrhoidal flow, or the retrocession of some rheumatic or gouty congestions. One of the valvular diseases of the heart is well known to induce rapid congestion of the lungs, namely, aortic insufficiency. We observed a distinct example of that variety in our special clinic at the Hahnemann Hospital last winter.

We will finally cite another variety of congestion which is due to a mechanical and obvious cause, viz.: the rapid influx of blood that takes place in the collapsed lung when an abundant pleuritic effusion is too suddenly removed. Syncope and death are known to have been brought about in that manner.

Now if we look into the *modus operandi* of the "rush of blood" in all the varieties above described, with the exception of the last one, we notice that it can only take place through the bronchial arteries; and knowing the controlling power that the sympathetic possesses over the smaller arterial ramifications, one readily arrives at the conclusion that at the root of the trouble is a vaso-motor perturbation, probably of reflex nature. This view the author most emphatically upholds. Only, when he says that "the vaso-motor nerves, the nerves which control the dilatation of the blood-vessels, are paralyzed, and the enlargement of these vessels is the natural result," he, curiously enough, states the reverse of what he means. Whereas, if it were the vaso-dilators that suffered paralysis, the consequence would be that the vaso-constrictors will gain the upper hand, and that pulmonary ischæmia, instead of hyperæmia, would be produced. As a matter of fact, in the light of the vaso-motor hypothesis, it is the vaso-constrictors that suffer a temporary paralysis, thus allowing the vaso-dilators full play.

But this is of little importance after all, as the whole matter is yet one of speculation. Whatever the explanation may be, the fact remains that this interesting group of active, or idiopathic congestions, constitutes a distinct morbid state, that deserves to occupy a special niche by the side of pneumonia and pleurisy, with which it has so long been, and is still so often confounded.

Aconite is of course our chief remedy in all the varieties of this group, being exactly homœopathic to the morbid state, and nothing is more prompt and satisfactory than its action when given in time.

Concerning the passive hyperæmia of the lung, the author differentiates between the stagnation of blood dependent upon cardiac debility, or some adynamic condition of the system and that which is due to a mechanical obstruction as is the case in valvular heart disease.

This group being much more familiar to the average practitioner than the former, we shall not expatiate upon it, regretting that lack of space precludes us from citing some of the happy remarks by which the author infuses life into his subject.

Lastly, under the caption of "Pulmonary Catarrh," he shows how bronchiolitis and alveolitis may at any time complicate the course of a congestion, and there is some truth in that. But it would have been at least as much to the

point to hold up to view the fact that many of the sudden turns taken by pleurisy, pneumonia, broncho-pneumonia, in children especially, would be hard to account for without the interference of a congestive element.

Such is in the chief purport of Dr. Nichol's attractive little pamphlet. It stands as an example of honest and independent inquiry, and commends itself to the profession as a valuable contribution to pulmonary pathology.

DR. ARNULPHY.

LECONS DE CLINIQUE CHIRURGICALE professèes a l'hopital Saint Louis, etc., etc. Par M. le Dr. Péan, etc. Avec figures dans le texte. Paris, Félix Alcan, editeur, 1888; pp. 1407.

LECTURES ON CLINICAL SURGERY given at the Hospital Saint Louis, Paris. By Dr. Péan, member of the Academy of Medicine, etc.

This is another of Péan's huge volumes, the sixth of its kind, and as usual we find it full of practical and indispensable information. Its contents include twelve clinical lectures, the brief and essential history of hospital cases illustrating the surgery of all the bodily regions, grouped into chapters under their several heads, and a continuation of his very remarkable table of gastrotomies, or laparotomies, to the end of the year 1886.

While all of the clinical lectures are useful and interesting, those upon exostoses of the pelvis; upon the treatment of fluid tumors within the abdomen and the pelvis by the suppurative process; upon laparotomy in lipomata and tuberculous tumors of the mesentery; and upon the indication for uterine and ovarian castration are especially so.

Concerning the pelvic exostoses we have space for the following: "The *prognosis* of these growths is very variable. While their nature is essentially benign, we have seen that by their seat and volume they may occasion such complications as are often serious and sometimes fatal. Those which are extra-pelvic are really the least harmful. On

the contrary, as I have already told you, certain intra-pelvic growths of this kind are very bad. Among these latter the worst are those which are located in the lower pelvis, especially those which are attached to the posterior wall of the pubis, where they may occasion a retention of urine or a perforation of the bladder that will be fatal. Those also which are attached to the hollow of the sacrum, and to the internal iliac fossa, or which lift the upper part of the sacrum in order that they may grow toward the abdominal cavity are bad enough."

The lecture on uterine and ovarian castration is a very remarkable one, being written in the same vein as the author's pamphlet, which appeared as late as 1867, under the title: *Can ovariotomy be performed in Paris with a good chance of success?** He has now answered that question many times over, and since this lecture on uterine castration first saw the light in 1886, he has also demonstrated the value and the safety of vaginal hysterectomy. Of the conditions that may justify this particular expedient we are told that "(1) if, with a certain proportion of patients who are afflicted with large tumors of the uterus and its appendages, it is difficult to recognize their seat and their relation with the pelvic and other organs, the same is equally true of small tumors. Sometimes even these latter are unrecognized although they are the source of suffering that has resisted all medical treatment; that (2) the removal of ovarian and tubal tumors almost always necessitates the supra-vaginal operation; that (3) uterine castration, when that organ is the seat of small tumors, should always be performed by the vagina; that (4) for the so-called neuralgia of the womb and the ovaries, uterine castration gives better results than the removal of the appendages; that (5) when the surgeon fails to find any recognizable tumor in this organ or its annexæ, he should not hastily conclude

*L'Ovariotomie peut-elle etre faite a Paris avec des chances favorables de succes?

** Gazette des Hopitaux 1886—p. 544.

that there certainly is none, for by this new method of ablation he may discover a growth which had hitherto passed unperceived; and that (6) in this case, if it is very difficult to remove it per vaginam, he should not hesitate to do it by the abdominal method."

We shall have something to say upon this subject in the near future, in a hospital case where the removal of the ovaries could not be safely accomplished, because of the most intimate and inveterate adhesions, we afterward took away the uterus per vaginam by Péan's method, leaving the ovaries behind. The patient made a good recovery and although more than a year has elapsed has had no return of her hystero-epilepsy. Still the proposal to exterpate the uterus, or uterine castration for any cause other than cancer, or multiple fibroids is not likely to become very popular with the profession.

The author's tables at the end of the volume, the sixth of the series furnish all the important details of 182 additional cases, making a consecutive list of 945 in all in which for various purposes, but chiefly for the removal of tumors, he has made the abdominal section. Of the 182 cases here given, 71 were tumors of the ovary, the tubes, and of the broad ligaments, 70 of which recovered and one died. And of these 182 cases, 90 were benign and malignant tumors of the uterus, 23 of which were removed by the hypogastrium with 20 recoveries and 3 deaths; and 67 by the vagina with 66 recoveries and only one death.

LUDLAM.

Miscellaneous Items.

An adjourned discussion of the treatment of "la grippe," will be held at the next meeting of the Clinical Society, Saturday evening, January 25.——The idea of enlarging the CLINIQUE has proved to be very popular with our subscribers far and near.——The Faith-cure healers have been run over by the grippe-car.——The *Medical Counselor* has merged with the *Medical Era.*——Since the holidays there is quite an influx of M. D.'s for a partial course.——The latest mail from Australia announces the marriage of Chris. Bollen, M. D.——The new lecture card for the last half of the term is just out.——Prof. Shears has been ill for a fortnight, but is better now.——The students say that Prof. Halbert takes the palm as the superior teacher of anatomy in Chicago.——Our manager says that to his certain knowledge, the *remitting* fever is prevalent, and that, fortunately for his coffers, one attack does not give exemption.——Don't fail to read the new "ad" of Sanitas in the outskirts of this number.——Enquiries concerning the next Alumni meeting should be addressed to Dr. F. W. Gordon, Sterling, Ill., president, or to Dr. R. Ludlam, Jr., Chicago, secretary.——Dr. H. R. Clark, of Beloit, Wis., died of pneumonia, January 11.——Mr. W. R. Strong, a member of the present college class, having lost his little child of a year, has the sympathy of the Faculty and the students.——The extension of the winter term for another month precludes the possibility of having a Post-Graduate course this year.——Concerning the universal topic, somebody says there are

NO EXEMPTS.

"Joy, and temperance, and repose
Slam the door in the doctor's nose."
But the influenza, with a grin,
Slams it open and brings him in.